The Commonwealth of Massachusetts
Executive Office of Health and Human Services
www.mass.gov/masshealth

MassHealth Hospice Election Form

Instructions
This form must be completed whenever a MassHealth member chooses to elect or stop hospice services, to disenroll from hospice services, or to change hospice provider. MassHealth does not pay for hospice services unless a completed MassHealth Hospice Election Form has been submitted, and will not pay for hospice services provided before the effective date entered on the form. The effective date for hospice services may not be earlier than the date the member or the member's representative signs the form.

Attention: MassHealth MCO Members: MassHealth MCO members can elect hospice services through their MCO. MCO members who elect hospice services by signing Section B of this form will be automatically disenrolled from their MCO.

The hospice provider must complete Section A below and then complete either Section B1 or B2 (Hospice Election), Section C (Hospice Revocation), or Section E (Hospice Change) with the member or the member's representative. The hospice provider may complete Section D (Hospice Disenrollment) without the signature of the member or the member's representative.

Fax the completed form to 617-886-8133 or 617-886-8134 or mail the form to:
MassHealth Hospice Unit
UMMS-CHCF
529 Main Street
Charlestown, MA 02129

Section A: Hospice Provider and Member Information *(Required)*

MassHealth Provider Number/NPI:
_____

Hospice Provider Name, Address, and Phone No.: _____
_____
_____

MassHealth Member ID: _____

MassHealth Member Name and Address: _____
_____
_____

Member Diagnosis: _____
_____

Section B: Hospice Election *(Complete this section when the member chooses hospice services.)*

Section B(1): Hospice election for MassHealth members aged 21 and older:

Effective date of hospice election: ___/___/___

Member Statement
I agree to get all care for my terminal illness from the hospice provider named above. I know that hospice services are for my care and comfort, and not for curing me. I understand that unless I sign a form to stop hospice services, I have to get all care for my terminal illness from the hospice provider.

_____ ___/___/___
Signature of Member or Member's Representative *Date*

Check one of the following boxes and print the name.

☐ Member: _____
☐ Member's representative: _____

Section B(2): Hospice election for MassHealth members under 21 years of age.

MassHealth members under age 21 who elect hospice services have coverage for curative treatment and all medically necessary services for which they are eligible.

Effective date of hospice election: ___/___/___

Member Statement

I agree to get all care for my terminal illness from the hospice provider named above. I know that hospice services are for my care and comfort. I understand that unless I sign a form to stop hospice services, I have to get all care for my terminal illness from the hospice provider.

_____ ___/___/___
Signature of Member or Member's Representative *Date*

_____
Printed Name of Member or Member's Representative

Section C: Hospice Revocation *(Complete this section when the member decides to stop hospice services.)*

Effective date of hospice revocation: ___/___/___

Member Statement

I want to stop receiving hospice services and begin receiving MassHealth benefits from any MassHealth provider. I know that by signing this form, MassHealth will not pay for hospice services for me as of the revocation date. I can still get hospice coverage later if I sign up again.

_____ ___/___/___
Signature of Member or Member's Representative *Date*

Check one of the following boxes and print the name.

_____
Printed Name of Member or Member's Representative

Section D: Hospice Disenrollment *(Complete this section to disenroll the member from hospice.)*

Effective date of hospice disenrollment: ___/___/___

Select reason for disenrollment:

☐ Death *(The member has died.)*
☐ Loss of eligibility *(The member is no longer in a MassHealth benefit plan that covers hospice services, or the member is not eligible for MassHealth.)*
☐ Health-care needs changed *(The member's health condition has improved and the six-month prognosis has changed.)*
☐ Enrolled in all-inclusive managed care plan *(The member's health-care needs will be managed by the plan.)*
☐ Other *(If the reason is none of the above, explain the reason in detail.):*

_____
_____

_____
Signature of Hospice Provider Staff Person Completing the Form

Section E: Hospice Change *(Complete this section when the member is changing hospice providers.)*

A **newly designated hospice provider** must complete Section A and this section, including getting a date and signature from the member or the member's representative, and submit the completed form to MassHealth at the address appearing above.

Effective date of hospice discharge from previous hospice provider*:* ___/___/___

Effective date for the newly designated hospice provider: ___/___/___

Member Statement

I want to change to a different hospice provider.

The hospice provider I have now is: _____

The hospice provider I want to change to is: _____

_____ ___/___/___

Signature of Member or Member's Representative *Date*

Check one of the following boxes and print the name.

_____

Printed Name of Member or Member's Representative